SENATE BILL REPORT SB 5888

As of February 16, 2015

Title: An act relating to near fatality incidents of children who have received services from the department of social and health services.

Brief Description: Concerning near fatality incidents of children who have received services from the department of social and health services.

Sponsors: Senators O'Ban and Miloscia.

Brief History:

Committee Activity: Human Services, Mental Health & Housing: 2/17/15.

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Staff: Alison Mendiola (786-7444)

Background: Child Fatality Reviews. The Department of Social and Health Services (DSHS) must conduct a child fatality review when a fatality is suspected of being caused by abuse or neglect of a minor who is in the care of or receiving services from DSHS or a supervising agency or the minor had been in care of DSHS or a supervising agency within one year preceding the minor's death. DSHS must assure that persons assigned to a child fatality review team have no previous involvement in the child's case and that the review team includes individuals who have professional expertise pertinent to the dynamics of the case under review.

Within 180 days of the fatality, DSHS must issue a report of the results of the review. Reports must be distributed to the Legislature and posted online. A child fatality review report is subject to public disclosure. DSHS is expressly authorized to redact confidential information contained in a review report according to existing state and federal laws protecting the privacy of victims of child abuse and neglect, including laws regarding the confidentiality of postmortem and autopsy reports.

<u>Near Fatality Child Reviews.</u> In the event of a near fatality of a minor in the care of or receiving services from DSHS or a supervising agency, or a minor who had been in the care or receiving services from DSHS or a supervising agency, within one year of the preceding near fatality, DSHS must notify the Office of the Family and Children's Ombuds (OFCO). DSHS may conduct a review at its discretion or at the request of the OFCO.

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A child fatality or near-fatality review is subject to discovery in a civil or administrative proceeding. However, any use or admission into evidence is limited as follows:

- Employees of DSHS cannot be questioned in a civil or administrative proceeding relating to the work of the child fatality review team, the incident under review, or the employee's statements, thoughts, or impressions or those of the review team members or others who provided information to the review team.
- A witness may not be examined regarding the witness's interactions with the child fatality or near-fatality review, including whether the person was interviewed during the review, questions asked during the review, and answers provided by the person.
- Documents prepared for a review team are inadmissible in a civil or administrative proceeding. Documents that existed before use or consideration by the review team or that were created independently of a fatality or near-fatality review may still be admissible. The limitation also does not apply to licensing or disciplinary proceedings relating to DSHS's efforts to revoke or suspend a license based on allegations of misconduct or unprofessional conduct connected with a near fatality or a fatality being reviewed.

OFCO. The OFCO was created in 1996 to protect children and parents from harmful agency action or inaction, and to make agency officials and state policymakers aware of system-wide issues in the child protection and child welfare system. The OFCO is part of the Governor's Office and operates independently from DSHS and other state agencies, acting as a neutral fact-finder, not as an advocate. The OFCO's responsibilities include investigating complaints related to child protective services or child welfare services, monitoring the procedures used by DSHS in delivering family and children's services, and providing information about the rights and responsibilities of individuals receiving family and children's services and the procedures for providing those services. To perform these duties, the OFCO has authority:

- to interview children in state care;
- to access, inspect, and copy all records, information, or documents in DSHS' possession that the OFCO considers necessary to conduct an investigation; and
- to have unrestricted online access to the case and management information system operated by DSHS.

The OFCO must issue an annual report to the Legislature on the implementation of the recommendations from reviews of child fatalities.

Summary of Bill: In the event of a near fatality of a minor in the care of or receiving services from DSHS or a supervising agency or a minor who had been receiving such care in the preceding three months of the near fatal incident, DSHS must notify OFCO and conduct a review of the near fatality.

When a social worker or other employee of the child protective services of DSHS responds to an allegation of child abuse or neglect and takes no action or does not remove the child from the home, and there is a subsequent allegation of abuse or neglect resulting in a near fatality within one year of the initial allegation that is screened in and open for investigation by DSHS, DSHS must immediately conduct a review of the social worker's and social worker's supervisor's files and actions taken during the initial report of alleged child abuse or neglect. The purpose of the review is to determine if there were any errors by the employees

under DSHS policy, rule, or state statute. If any violations of policy, rule, or statute are found, DSHS must conduct a formal employee investigation.

Appropriation: None.

Fiscal Note: Requested on February 13, 2015.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

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